STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Victorian Rehabilitation & Nursing Care Cntr	100 New Turnpike Road Troy, NY 12182

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews and interviews, the facility failed to ensure that alleged violations involving elopement were reported immediately, but not less than two hours later to the State Survey Agency for one (Resident #5) of two residents reviewed for elopement. Specifically, the facility was unable to locate Resident #5 until Health Care Proxy #1 informed the facility that Resident #5 had left the facility and was in a local hospital emergency department. The incident was not reported to the New York State Department of Health.Cross reference F689This is evidenced by:The Policy and Procedure titled Elopement, dated 7/14/2021, stated if an employee discovered a resident was missing, they should make a thorough search of the building and premises, and notify the administer and director of nursing services, the resident's legal representative, attending physician, and law enforcement agencies. Resident #5 Residentˆ#5 was admitted ˆto the facility with the diagnoses ofˆalcohol abuse (when a person can't stop drinking even when it puts their health and safety at risk) with withdrawal delirium (a sudden, serious change in mental state causing confusion, disorientation, memory problems, and fluctuating alertness), dysphagia (difficulty swallowing), and opioid dependence (a mental health condition where a pattern of opioid use affects health and daily life).ˆThe Minimum Data Setˆ(an assessment tool) datedˆ10/18/2025ˆdocumented the residentˆwas understood, could understand others,ˆand had a Brief Interview for Mental Status score of 14/15, indicative of intact cognition.ˆResident #5 was assessed for wandering in the Minimum Data Set and documented that no wandering behavior had occurred.ˆˆThe Interdisciplinary Assessment completed on 10/13/2025 documented the resident was an elopement risk.ˆ Resident #5 late entry Progress note dated 10/18/2025 at 11:43 AM written by Licensed Practical Nurse #5 stated they were notified by Licensed Practical Nurse #2 that Resident #5 was not in their room or in the lobby. They notified Director of Nursing #1, the medical provider, and Health Care Proxy #1 and told them Resident #5 had left the facility against medical advice. After receiving information from Health Care Proxy #1 they confirmed Resident #5 was in a local hospital emergency department. They made social services aware of the discharge, who would inform Adult Protective Services. During a telephone interview on 1/7/2026 at 1:14 PM, Health Care Proxy #1 stated Resident #5 left in the middle of the night, but they were called until 9:00 AM on 10/18/2025. They stated Licensed Practical Nurse #5 asked them if they knew where Resident #5 was because they could not be located. Health Care Proxy #1 stated they had record portal to the local hospital and had an alert from that morning that Resident #5 was in the emergency department since around 8:00 AM. They stated they then called the facility back and informed the facility where the resident was. They stated they went to see Resident #5 in the emergency department and Resident #5 had all their belongings with him. During an interview on 1/07/2026 at 3:00 PM Director of Nursing #1ˆstatedˆthe resident was alert and oriented and the facility had no responsibility if the resident wanted to leave.ˆˆDirector of Nursing #1 stated they watched the camera footage on 10/18/2025 and stated Resident #5 had all their belongings in the lobby at 6:42 AM and they watched Resident #5 leave through the front door after an unnamed staff member returned from a break. They stated again that the resident was alert and oriented and they could not stop the resident from leaving. They stated this incident was not an elopement because the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026

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Troy Victorian Rehabilitation & Nursing Care Cntr	100 New Turnpike Road Troy, NY 12182

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was alert and oriented, so it did not need to be reported.10 New York Codes, Rules and Regulations 415.4(b)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER Troy Victorian Rehabilitation & Nursing Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 100 New Turnpike Road Troy, NY 12182	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record reviews and interviews, the facility failed to ensure that comprehensive care plan interventions were implemented, for 2 (two) (Resident #5 and Resident #9) of 18 residents reviewed for care plans. Specifically, Resident #5 and Resident #9 were not adequately supervised as per their care plans resulting in elopement. Cross reference F689 This is evidenced by:Care Plan Policy and Procedure dated 06/20/2025 documented:INTENT: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. PROCEDURE: 1. The following health care professionals contribute to the Interdisciplinary Care Plan by collaboration and direct documentation: Registered Nurse, Licensed Practical Nurse, Certified Nurse Assistant, Physical Therapist, Occupational Therapist, Speech Therapist, Respiratory Therapist, Activity Director, Social Services Coordinator, Dietitian, Physician and other appropriate members of the Care Plan Team. Other specialty areas available for consultation when needed include, but are not limited to diabetic, pain, wound, psychological, hospice and pharmacy professionals.2. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Resident #5 was admitted to the facility with the diagnoses of alcohol abuse (when a person can't stop drinking even when it puts their health and safety at risk) with withdrawal delirium (a sudden, serious change in mental state causing confusion, disorientation, memory problems, and fluctuating alertness), dysphagia (difficulty swallowing), and opioid dependence (a mental health condition where a pattern of opioid use affects health and daily life). The Minimum Data Set (an assessment tool) dated 10/18/2025 documented the resident was understood, could understand others, and had a Brief Interview for Mental Status score of 14/15, indicative of intact cognition. Resident #5 Comprehensive Care Plan titled Behavior Problem: Wandering and Elopement risk dated 10/15/2025; Goals, Resident to be maintained safely under supervision of facility staff, as evidenced by remaining away from unsafe areas and within the facility, unless under escort by family or staff, Interventions added the intervention of documenting and notifying providers of intensity, duration, or frequency of behavior and to redirect resident.Resident #5 Progress Note dated 10/16/2025 at 12:34 AM noted the resident stated they wanted to leave against medical advice due to not receiving pain medication but was convinced to stay.Resident #5 Progress Note dated 10/17/2025 at 6:33 AM written by Licensed Practical Nurse #5 stated the resident was noted to be walking up and down the hallway demanding medication.Resident #5 Progress Note dated 10/17/2025 at 8:08 AM written by Licensed Practical Nurse #6 stated the resident attempted to leave through the front door several times, yelling and being aggressive but was calmed.Resident #5 late entry Progress note dated 10/18/2025 at 11:43 AM written by Licensed Practical Nurse #5 stated Resident #5 was yelling about their pain medication. They stated the resident walked to the lobby, sat in a chair by the door, and fell asleep. They were notified by Licensed Practical Nurse #2 that Resident #5 was not in their room or in the lobby. They notified Director of Nursing #1, the medical provider, and Health Care Proxy #1 and told them Resident #5 had left the facility against medical advice.During a telephone interview on 01/7/2026 at 12:15 PM, Certified Nurse Aide #3 stated Resident #5 was on their assignment on the evening shift on 10/17/2025. They stated during that shift the resident stated they wanted to leave because they found the facility too restrictive (couldn't smoke for example). They stated they did inform Licensed Practical Nurse #5. They stated the resident did not try to leave during the shift. During a telephone interview on 01/7/2026 at 12:26 PM, Certified Nurse Aide #4 stated Resident #5 was on their (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assignment on the overnight shift 10/17/2025-10/18/2025. They stated the resident stated they wanted to leave and they informed their supervisor (Licensed Practical Nurse #5). They stated the resident liked to sleep in the front lobby and had slept in the lobby on their shift. The resident made no attempts to physically leave and Certified Nurse Aide #4 stated Resident #5 was in their room when they left.During a telephone interview on 01/7/2026 at 1:14 PM, Health Care Proxy #1 stated Resident #5 left in the middle of the night but they were called until 9:00 AM on 10/18/2025. They stated Licensed Practical Nurse #5 asked them if they knew where Resident #5 was because they could not be located. Health Care Proxy #1 stated the facility told them Resident #5 had the right to leave and there was no risk but they couldn't remember which staff member told them that.During an interview on 01/7/2026 at 1:40 PM, Licensed Practical Nurse #2 stated when they attempted to administer morning medications to the resident on 10/18/2025, the resident was not in their room. They asked other staff if they knew where Resident #5 was and no one knew where they were. Licensed Practical Nurse #2 stated they went to their supervisor (Licensed Practical Nurse #5) and informed them. They stated they performed a head count of the unit and the only unaccounted for resident was Resident #5. During a phone interview on 01/7/2026 at 1:45 PM, Licensed Practical Nurse #5 confirmed they were the overnight supervisor on 10/17/2025-10/18/2025. They stated the resident left against medical advice. They stated they were informed by Licensed Practical Nurse #2 that the resident wasn't able to be located. They stated they spoke to the resident's Health Care Proxy who informed them that Resident #5 was in the emergency department of a local hospital. They stated they called Director of Nursing #1 who watched the security cameras in the lobby at their home and stated the resident was an against medical advice discharge and instructed them on how to discharge the resident from the electronic medical system. They stated they had last seen the resident in the lobby at around 6:00 AM on 10/18/2025. They stated they did not have a discussion with the resident about leaving against medical advice or asking them to sign any forms.During an interview on 01/07/2026 at 3:00 PM Director of Nursing #1 stated the resident was alert and oriented and the facility had no responsibility if the resident wanted to leave. Director of Nursing #1 stated they watched the camera footage on 10/18/2025 and stated they watched Resident #5 leave through the front door after an unnamed staff member returned from a break. They stated again that the resident was alert and oriented and they could not stop the resident from leaving. They stated this incident was not an elopement because the resident was alert and oriented. Director of Nursing #1 stated they did not need to supervise the resident because the resident was alert and oriented and allowed to leave at any time. Resident #9Resident #9 was admitted to the facility with diagnoses of Alzheimer's unspecified (progressive brain disorder that slowly destroys memory and thinking skills), cognitive communication deficit (condition that affects how individuals think and communicate), and muscle weakness generalized (muscles aren't as strong as they should be). The Minimum Data Set (an assessment tool) dated 11/26/2025, documented the resident could be understood and could understand others with severely impaired cognition.New York State Department of Health received an Incident reported by facility on 11/16/2025 at 2:20 PM, which documented Resident #9 had eloped from their facility.Facility Investigation for Resident #9 elopement dated 11/16/2025, document thorough investigation and that Resident # 9 was able to leave facility.Resident #9 Care Plan titled Wandering/Elopement effective dated 11/03/2025, documented Resident was at risk for wandering into unsafe areas, or for elopement out of the building, without supervision. Goals documented resident will be maintained safely under supervision of facility staff, as evidenced by remaining away from unsafe areas and within the facility, unless under escort by family or staff, over the next 30 days. Interventions documented, identify pattern of behavior (specify): Activities, Medical, Nursing, Social Services Active Effective: 11/03/2025 Document in the progress notes intensity, duration or frequency of behavior. Activities, Medical, Nursing, Social Services Active Effective: 11/03/2025 Orient to daily routines. Activities, Dietary, Nursing, Occupational Therapy, Physical Therapy, Social Services Active Effective: 11/03/2025 Refer for Psychiatric Consult as per Medical Doctor order. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical, Nursing, Social Services Active Effective: 11/03/2025 Ensure proper placement of ankle alert and check for any malfunction.During an interview on 01/12/2026 at 1:30 PM, Dietary Aide #1, stated on 11/16/2026 they saw Resident #9 through the kitchen window outside north rehabilitation door alone in their wheelchair. They stated they immediately notified their supervisor. During an interview on 01/12/2026 at 1:40 PM, Director of Nursing #1, stated that the door Resident #9 left facility from is an emergency exit and alarmed as such, it was not a Wandergaurd alarmed door.During an interview on 01/13/2026 at 1:35 PM, Director of Nursing #1, stated it is a shared responsibility of all staff to know and implement care plans for each resident. They stated the process is with all admissions, quarterly assessments, or significant changes care plans are updated by a nurse manager or someone above in administration. They stated once the care plan was updated it was the responsibility of the person who updated the care plan to be sure the certified nursing assistant care card was updated at the same time.10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during survey, the facility failed to ensure residents at risk of elopement remained under supervision for two (2) (Resident's #5 and #9) of four (4) residents reviewed for elopement risk. Specifically, (a.) Resident #5 left the faciity on [DATE] without the facility's knowledge and was not located until hours later; and (b.) Resident #9 was able to exit the facility on 11/16/2025 and was located shortly after on facility grounds. This resulted in Immediate Jeopardy and Substandard Quality of Care to Resident #5's health and safety, and no actual harm with potential for more than minimal harm that was not Immediate Jeopardy for Resident #9.This is evidenced by:The policy and procedure titled, Elopement, dated 07/14/2021, stated if an employee discovered a resident was missing, they should make a thorough search of the building and premises, and notify the Administrator and Director of Nursing Services, the resident's legal representative, attending physician, and law enforcement agencies. The Emergency Preparedness Section V (five): Emergency Response titled Missing Resident, dated 10/2021, stated a Code Pink would be announced with the resident's unit and a search would start of the facility and surrounding grounds. If the resident was not found within 10 minutes, the facility administrator/incident commander was to call the police to report the resident missing, document the time the resident was noticed to be missing, search progress and contacts. The policy and procedure titled, Against Medical Advice (AMA) Policy, dated 11/2025, stated the definition of against medical advice discharge, is a cognitively intact resident who willingly leaves the facility against the advice of the professional licensed staff and without the order of the treating physician. The policy stated information would be provided about the risks of leaving against professional advice. They documented the resident or decision maker would be asked to sign an Against Medical Advice document which would be counter signed by Nursing/Social Work. Careful, concise, and comprehensive documentation will be placed to the medical record regarding any and all education, counseling, options, resident/responsible party reactions and any and all actions taken by the Facility, including contact to physician and Adult Protective Services. Resident #5Resident #5 was admitted to the facility with the diagnoses of alcohol abuse (medical condition that impairs the ability to stop or control alcohol use despite harmful consequences) with withdrawal delirium (a sudden, serious change in mental state causing confusion, disorientation, memory problems, and fluctuating alertness), dysphagia (difficulty swallowing), and opioid dependence (a physical reaction to chronic opioid use where withdrawal is precipitated upon abrupt discontinuation). The Minimum Data Set (an assessment tool) dated 10/18/2025 documented the resident was understood, could understand others, and had a Brief Interview for Mental Status score of 14/15, indicative of intact cognition. The Interdisciplinary Assessment completed on 10/13/2025 documented the resident was an elopement risk. Resident #5's Comprehensive Care Plan titled, Behavior Problem: Wandering and Elopement risk dated 10/15/2025; Goals, Resident to be maintained safely under supervision of facility staff, as evidenced by remaining away from unsafe areas and within the facility, unless under escort by family or staff, Interventions include: documenting and notifying providers of intensity, duration, or frequency of behavior and to redirect resident. Resident #5's Comprehensive Care Plan titled, Substance Use Disorder History dated 10/15/2025 documented the resident had a current history of substance use disorder which included drug-seeking whether by prescription or by unauthorized means. Interventions included administer medications as ordered for cessation and/or nutritional support, consult follow ups as ordered, monitor for signs/symptoms of acute intoxication or potential substance use, monitor liver function labs, report abnormal to PCP (primary care provider), promote environment of judgement-free and supportive communication, and Social Work/Psychology/Psychiatric consults as indicated. Resident #5's progress note dated 10/13/2025 written by Assistant Director of Nursing #1 documented the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident arrived at the facility and was alert and oriented, but an electronic monitoring device was applied for wandering tendency. Resident #5's progress note dated 10/16/2025 at 12:34 AM by Licensed Practical Nurse #10 documented the resident stated they wanted to leave against medical advice due to not receiving pain medication but was convinced to stay. Resident #5's progress note dated 10/17/2025 at 6:33 AM written by Licensed Practical Nurse #5 documented the resident was noted to be walking up and down the hallway demanding medication. Resident #5's progress note dated 10/17/2025 at 8:08 AM written by Licensed Practical Nurse #6 documented the resident attempted to leave through the front door several times, yelling and being aggressive but was calmed. There was no documented evidence the medical provider was notified about Resident #5's statements to leave against medical advice or that the resident attempted to leave the facility.Resident #5 late entry progress note dated 10/18/2025 at 11:43 AM written by Licensed Practical Nurse #5 documented Resident #5 was yelling about their pain medication, pacing up and down the hallway and yelling the nurses had given them tramadol at 2000 and I'm going to need another dose I have pain in my legs. It further documented Resident #5 was talking fast in a loud voice, sweating and swearing. Licensed Practical Nurse #5 documented they told Resident #5 that they would speak to the physician about an extra dose of tramadol in which they did and then offered Resident #5 a topical analgesic and Resident #5 refused and continued to pace up and down the hallways. They documented the resident took a shower and then walked to the front lobby, sat in a chair by the door, and fell asleep. It further documented facility staff allowed the resident to sleep in the chair because prior the resident had continued onset pain while awake and was calm at the time. When approached for medication pass, the resident was not in the chair and not in their room. They notified Director of Nursing #1, the medical provider, and Health Care Proxy #1 and told them Resident #5 had left the facility against medical advice. After receiving information from Health Care Proxy #1 they confirmed Resident #5 was in a local hospital emergency department. They made social services aware of the discharge, who would inform Adult Protective Services. There was no documented evidence of any education, counseling, options, resident/responsible party reactions or any discussions surrounding the risks of Resident #5 signing out against medical advice.The Medication Administration Record for October 2025 documented Resident #5 was administered Clonidine HCl 0.2 milligrams tablet by oral route on 10/18/2025 at 3:00 AM. During a telephone interview on 01/07/2026 at 12:15 PM, Certified Nurse Aide #3 stated Resident #5 was on their assignment during the evening shift on 10/17/2025. They stated during that shift the resident stated they wanted to leave because they found the facility too restrictive (couldn't smoke for example). They stated they did inform Licensed Practical Nurse #5. They stated the resident did not try to leave during that shift. During a telephone interview on 01/07/2026 at 12:26 PM, Certified Nurse Aide #4 stated Resident #5 was on their assignment during the overnight shift 10/17/2025 - 10/18/2025. They stated the resident stated they wanted to leave, and they informed their supervisor (Licensed Practical Nurse #5). They stated the resident liked to sleep in the front lobby and had slept in the lobby on their shift. The resident made no attempts to physically leave, and Certified Nurse Aide #4 stated Resident #5 was in their room when they left. They believed the resident had an electronic monitoring device on. During a telephone interview on 01/07/2026 at 1:14 PM, Health Care Proxy #1 stated Resident #5 left in the middle of the night, but they were not called until 9:00 AM on 10/18/2025. They stated Licensed Practical Nurse #5 asked them if they knew where Resident #5 was because they could not be located. Health Care Proxy #1 stated they had access to the records portal at the local hospital and had an alert from that morning that Resident #5 was in the emergency department since around 8:00 AM. They stated they then called the facility back and informed the facility where the resident was. They stated they went to see Resident #5 in the emergency department and Resident #5 had all their belongings with them. The resident had minor injuries from a reported fall on the walk to the hospital. Health Care Proxy #1 stated the facility told them Resident #5 had the right to leave and there was no risk, but they could not remember which staff member told them that. They stated they were also told the resident had (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cut their electronic monitoring device off and left it on the front desk before exiting. During an interview on 01/07/2026 at 1:40 PM, Licensed Practical Nurse #2 stated when they attempted to administer morning medications to the resident on 10/18/2025 at around 7:30 AM, the resident was not in their room. They asked other staff if they knew where Resident #5 was, and no one knew where Resident #5 was located. Licensed Practical Nurse #2 stated they went to their supervisor (Licensed Practical Nurse #5) and informed them. They stated they performed a head count of the unit and the only resident unaccounted for was Resident #5. Licensed Practical Nurse #2 stated they did not recall if Resident #5 had an electronic monitoring device on or not. During a phone interview on 01/07/2026 at 1:45 PM, Licensed Practical Nurse #5 confirmed they were the overnight supervisor on 10/17/2025-10/18/2025. They stated the resident left against medical advice. They stated they were informed by Licensed Practical Nurse #2 that the resident was unable to be located and had removed their electronic monitoring device. They stated they spoke to the resident's Health Care Proxy, who informed them that Resident #5 was in the emergency department of a local hospital. They stated they called Director of Nursing #1, who watched the security cameras of the lobby from their home and stated the resident was an against medical advice discharge and instructed them on how to discharge the resident from the electronic medical system, using the time of 4:48 AM on 10/18/2025 as the time of discharge. They stated they called the local hospital and verified the resident was in their emergency department and gave a quick report to the emergency department nurse about Resident #5. They stated they had last seen the resident in the lobby at around 6:00 AM on 10/18/2025, but the resident did not have their belongings with them. They stated they did not have a discussion with the resident about leaving against medical advice or asked them to sign any forms. During a telephone interview on 01/07/2026 at 11:29 AM, hospital Registrar #1 stated Resident #5 was admitted to the emergency room at 7:54 AM on 10/18/2025. During an interview on 01/07/2026 at 3:00 PM, Director of Nursing #1 stated Resident #5 was alert and oriented and the facility had no responsibility if the resident wanted to leave. Director of Nursing #1 stated they watched the camera footage on 10/18/2025 and stated Resident #5 had all their belongings in the lobby at 6:42 AM and they watched Resident #5 leave through the front door after an unnamed staff member returned from a break. They further stated the resident was alert and oriented and they could not stop the resident from leaving. They stated this incident was not an elopement because the resident was alert and oriented. They stated an electronic monitoring device was placed on the resident when the resident was admitted based on their past admission in July 2025. The electronic monitoring device was removed the next day based on their Brief Interview for Mental Status. They stated Resident #5 did not have an electronic monitoring device on that night. Director of Nursing #1 stated they did not need to supervise the resident because the resident was alert and oriented and allowed to leave at any time. Resident #9Resident #9 was admitted to the facility with diagnoses of Alzheimer's unspecified (progressive brain disorder that slowly destroys memory and thinking skills), cognitive communication deficit (condition that affects how individuals think and communicate), and muscle weakness generalized (muscles aren't as strong as they should be). The Minimum Data Set, dated [DATE], documented the resident had severely impaired cognition, could be understood and could sometimes understand others.Resident #9's Care Plan titled, Wandering/Elopement effective dated 11/03/2025, documented Resident was at risk for wandering into unsafe areas, or for elopement out of the building, without supervision. Goals documented resident will be maintained safely under supervision of facility staff, as evidenced by remaining away from unsafe areas and within the facility, unless under escort by family or staff, over the next 30 days. Interventions documented, identify pattern of behavior (specify): Activities, Medical, Nursing, Social Services Active Effective: 11/03/2025 Document in the progress notes intensity, duration or frequency of behavior. Activities, Medical, Nursing, Social Services Active Effective: 11/03/2025 Orient to daily routines. Activities, Dietary, Nursing, Occupational Therapy, Physical Therapy, Social Services Active Effective: 11/03/2025 Refer for Psychiatric Consult as per Medical Doctor order. Medical, Nursing, Social Services Active (continued on next page)

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Troy Victorian Rehabilitation & Nursing Care Cntr	100 New Turnpike Road Troy, NY 12182

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Effective: 11/03/2025 Ensure proper placement of ankle alert and check for any malfunction.Resident #9 Treatment Administration Records dated 11/2025, documented electronic monitoring device checks every shift in place starting 11/03/2025.Facility investigation documented on 11/16/2025 at approximately 11:12 AM, Housekeeper #1 heard an alarm from One (1) North exit door, they immediately alerted Licensed Practical Nurse #2 and nursing supervisor. An immediate resident accountability was initiated. Resident seen by dietary staff from kitchen window and returned to the facility unharmed. Investigation statement dated 11/16/2025, Registered Nurse #3, last saw the resident at approximately 11:00 AM on their unit sitting in their wheelchair. Investigation statement dated 11/16/2025 by Dietary aide #2, stated at approximately 11:45 AM they noticed a resident outside by the One (1) North exit door, two (2) of their coworkers went to the resident and brought them inside.During an interview on 01/12/2026 at 1:30 PM, Dietary Aide #1 stated they saw Resident #9 through the kitchen window outside the North rehabilitation door alone in their wheelchair. They stated they immediately notified their supervisor. During an interview on 01/12/2026 at 1:40 PM, Director of Nursing #1, stated electronic monitoring device orders were never placed in Resident #9's Medication or Treatment Administration Record when ordered. Monitoring of residents electronic monitoring device started after their Quality Assurance audit proceeding the elopement incident on 11/17/2025. It was corrected and monitoring was added to the resident Treatment Administration Record. The admission or nurse manager was responsible for putting the electronic monitoring device orders in the chart. Director of Nursing #1 stated the door that Resident #9 left facility from is an emergency exit and alarmed as such, it is not an electronic monitoring device alarmed door. They stated interventions put in place through the facility have decreased elopement attempts.The facility was informed of Immediate Jeopardy status on 1/09/2026 at 6:10 PM. The facility took the following steps to lift the Immediate Jeopardy as of 1/11/2026: - As of 1/10/2026, it was confirmed by review of camera footage and interviews with six staff of various titles that the front door to the facility was manned.- As of 1/11/2026, record review of revised elopement policy dated 01/2026 document an addition of when a resident is found missing from the facility staff is to follow the missing person policy.- As of 1/11/2026, Record review of revised missing person policy dated 01/2026 documented the addition of residents that have not signed or declined to sign Against Medical Advice paperwork with additional steps of notifying Administrator #1 or Director of Nursing #1 immediately, notifying the police, as well as New York State Department of Health- As of 1/11/2026, according to provided roster and education sign off sheets, 93 percent of employees have been educated on elopement and missing person policies.- As of 1/11/2026, interviews with 11 different staff members of various titles confirmed they had all been educated on the revised elopement and missing person policies. 10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)